# HEALTH HISTORY

## PERSONAL INFORMATION

Name: Today's Date:
Primary Phone Number: Email:
Date of Birth (M/D/Y) Insurance Provider:
Emergency Contact (Name & Phone Number) Phone Number:
Job & Regular Duties (ie: computer work, driving, lifting):
How did you hear about us?

## EXPERIENCE AND PREFERENCES WITH MASSAGE THERAPY CARE

Have you seen a Massage Therapist before? NO YES When was your last visit?
What results are you hoping to achieve from your Massage Therapy sessions here?

__ relief from pain/discomfort (details)
__ corrective care – relieving the cause of the problem and the pain or discomfort
__ comprehensive care – bring the body to the highest state of functioning with massage therapy

If you have a specific concern, what makes it feel worse?
what makes it feel better?
Do you enjoy music during your treatment? no preference like/prefer dislike
Do you enjoy conversation during your treatment? sometimes, when appropriate yes no
What type of pressure do you like? gentle moderate deep

## CARE TEAM

Provide the **name** of your other health care professionals **and initial** each to give us permission to contact them.
**INITIAL** **Note:** This is optional but allows us to coordinate your care to achieve the best possible results .

Family Doctor: (name)
Physical Therapist: (name)
Personal Trainer: (name)
Acupuncturist/TCM: (name)
Chiropractor: (name)
Naturopath/Osteopath: (name)

## ACTIVITY

Please describe the physical activity you participate in regularly (e.g. cardio, stretching, resistance training, etc.)
Include frequency/length of time, etc.

What are your short & long term health goals?

## HEALTH HISTORY

List current prescription medications and over-the-counter drugs (ie: aspirin, ibuprofen, etc.)

List any supplements you are currently taking (ie: vitamins, recovery and protein shakes, etc.)

Do you have an infectious condition (ie: hepatitis, HIV, etc.)? NO YES Description:
Surgeries/Accidents - Date and description:
Allergies NO YES Describe allergen and reaction:
Women: Are you pregnant? How many weeks?

**Please mark all that apply and provide details where appropriate. C = Current P = Past**

**Muscle or Joint Condition or Injury**

Lower Back
Middle Back
Upper Back
Neck
Shoulder
Tendonitis
Broken or fractured bones
Muscles strains, joint sprains or dislocations

Bursitis
Arthritis
Scoliosis
Cramping
Osteoporosis
Other bone or joint disease

**Skin**

Eczema
Psoriasis
Rash
Warts

**Respiratory**

Breathing difficulty
Sinus problems
Asthma
COPD

**Circulatory**

Heart condition
Stroke/CVA
Phlebitis/varicose veins
Clotting disorder
High/Low blood pressure
Lymphedema
PMS/endometriosis
Raynaud's syndrome

**Other/Systemic**

Rheumatoid Arthritis
Cancer
Diabetes
Lupus
Anxiety
Depression
Chronic Fatigue Syndrome
Fibromyalgia

**Head/Neck**

Headaches
Migraines
Head Injury
Vision loss/disturbance
Hearing loss/disturbance
Seizures

**Digestive**

Irritable bowel syndrome
Crohn's/Colitis
Ulcers
Gas/bloat
Frequent diarrhea
Constipation

Please describe any areas of your body where you have pain, numbness, tension or any other problem areas.

Are you under medical supervision for any conditions not listed here? NO YES